

Healthy Way LA Eligibility Status Request

Date of Request: _____

Contact Information

Provider no. & name: _____

Phone no.: _____ Fax: _____

Requested by (name of contact person): _____

e-mail address: _____

Requested Information

Please identify name of client(s) whom you would like RMD to verify enrollment in Healthy Way LA. Provide as much information as possible.

Client #1

Full Name _____
DMH IS ID# _____
Date of Birth _____
SSN _____

Client #4

Full Name _____
DMH IS ID# _____
Date of Birth _____
SSN _____

Client #2

Full Name _____
DMH IS ID# _____
Date of Birth _____
SSN _____

Client #5

Full Name _____
DMH IS ID# _____
Date of Birth _____
SSN _____

Client #3

Full Name _____
DMH IS ID# _____
Date of Birth _____
SSN _____

Client #6

Full Name _____
DMH IS ID# _____
Date of Birth _____
SSN _____

RMD Tracking Information (RMD Use Only)

Request no.: _____

Opened by: _____

Request assigned to: _____

Closed by: _____

Date opened: _____

Date assigned: _____

Date closed: _____

This facsimile transmission may contain information that is privileged and confidential and is intended only for Healthy Way LA eligibility checks. If you are neither the intended recipient nor the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that disclosure, copying, use or distribution of this information is strictly prohibited. In addition, there are federal civil and criminal penalties for the misuse or inappropriate disclosure of confidential patient information. If you have received the transmission in error, please notify the contact person immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

Fax your request to Revenue Management Division at (213) 252-8889